4. The basis of a donated vehicle will be allowed to the extent of recognition of income resulting from the donation of the vehicle. Should a dispute arise between a provider and the Division as to the fair market value at the time of acquisition of a depreciable vehicle, an appraisal by a third party is required. The appraisal cost will be the sole responsibility of the nursing facility.

5. Historical cost will include the cost incurred to prepare the vehicle for use by the nursing facility.

6. When a vehicle is acquired by trading in an existing vehicle, the cost basis of the new vehicle shall be the sum of undepreciated cost basis of the traded vehicle plus the cash paid.

(E) Insurance.

1. Property Insurance. Insurance cost on property of the nursing facility used to provide nursing facility services. Property insurance should be reported on line 109 of the cost report version MSIR-1 (7-93).

2. Other Insurance. Liability, umbrella, vehicle and other general insurance for the nursing facility should be reported on line 140 of the cost report version MSIR-1 (7-93).

3. Workers' compensation insurance should be reported on the applicable payroll lines on the cost report for the employee salary groupings.

(F) Interest and Finance Costs.

1. Interest will be reimbursed for necessary loans for capital asset debt at the Chase Manhattan prime rate on September 1, 1994, plus two percentage (2%) points. For replacement beds, additional beds and new facilities placed in service after August 31, 1995, the prime rate will be updated annually on the first business day of each September based on the Chase Manhattan prime rate plus two percentage (2%) points.

2. Loans (including finance charges, prepaid costs and discounts) must be supported by evidence of a written agreement that funds were borrowed and repayment of the funds are required. The loan costs must be identifiable in the provider's accounting records, must be related to the reporting period in which the costs are claimed, and must be necessary for the operation, maintenance or acquisition of the provider's facility.

3. Necessary means that the loan be incurred to satisfy a financial need of the provider and for a purpose related to recipient care. Loans which result in excess funds or investments are not considered necessary.

4. A provider shall capitalize loan costs (i.e., lender's title and recording fees, appraisal fees, legal fees, escrow fees, and other closing costs), finance charges, prepaid interest and discounts. The loan costs shall be amortized over the life of the loan on a straight line basis.

5. If loans for capital asset debt exceed the facility asset value the interest associated with the portion of the loan or loans which exceeds the facility asset value shall not be allowable.

6. The following is an illustration of how allowable interest is calculated:

Outstanding Capital Asset Debt	$2,500,000
Term of Debt	25 years
Interest Rate (Chase Manhattan prime + 2%)	10 percent
Facility Asset Value	$2,000,000
Discount	$ 125,000
Loan Costs	$ 120,000

Allowable interest calculation - use the lessor of the facility asset value or the outstanding capital asset debt.

Other Allowable Borrowing Costs:

Discount - $2,000,000/ $2,500,000 x $125,000 =	$100,000
Loan Cost - $2,000,000/ $2,500,000 x $120,000=	$ 96,000
Allowable Interest - 2,000,000 x 10% =	$200,000
Discount - $100,000/ 25 years =	$ 4,000
Loan Cost - $96,000/ 25 years =	$ 3,840
Allowable Interest and Other Borrowing Costs	$207,840

7. Interest cost on vehicle debt for allowable vehicles per paragraph (7)(D)1. is treated as an administration cost and reported on line 139 of the cost report version MSIR-1 (7-93).

(G) Rental and Leases

1. Capitalized leases, as defined by GAAP, will be reimbursed in accordance with subsections (7)(C) and (7)(E).

2. Lease cost related to allowable vehicles per paragraph (7)(D)1. shall be treated as an administrative cost and be reported on line 139 of the cost report version MSIR-1 (7-93).

3. Operating leases, as defined by GAAP, will be part of the Fair Rental Value System.

(H) Real Estate and Personal Property Taxes. Taxes levied on or incurred by a facility used to provide nursing facility services.

(I) Value of Services of Employees

1. Except as provided for in this plan, the value of services performed by employees in the facility shall be included as an allowable cost area to the extent actually compensated, either to the employee or to the supplying organization.

2. Services rendered by volunteers such as those affiliated with the American Red Cross, hospital guilds, auxiliaries, private individuals and similar organizations shall not be an allowable cost, as the services have traditionally been rendered on a purely volunteer basis without expectation of any form of reimbursement by the organization through which the service is rendered or by the person rendering the service.

3. Services by priests, ministers, rabbis and similar type professionals shall be an allowable cost, provided that the services are not of a religious nature and are compensated. Costs of wardrobe and similar items shall not be allowable.

(J) Employee Benefits.

1. Retirement plans.

A. Contributions to Internal Revenue Service qualified retirement plans shall be an allowable cost.

B. Amounts funded to pension and qualified retirement plans, together with associated income, shall be recaptured, if not actually paid when due, as an offset to expenses on the cost report.

2. Deferred compensation plans.

A. Contributions shall be allowable costs when, and to the extent that, these costs are actually paid by the provider. Provider payments for unfunded deferred compensation plans will be considered an allowable cost only when paid to the participating employee.

B. Amounts paid by organizations to purchase tax-sheltered annuities for employees shall be treated as deferred compensation actually paid by the provider.

C. Amounts funded to deferred compensation plans together with associated income shall be recaptured, if not actually paid when due, as an offset to expenses on the cost report.

3. Types of insurance which are considered an allowable cost:

A. Credit life insurance (term insurance), if required as part of a mortgage loan agreement. An example, would be insurance on loans granted under certain federal programs.

B. Where the relative(s) or estate of the employee, excluding stockholders, partners and proprietors, is the beneficiary. This type of insurance is considered to be an employee benefit and is an allowable cost. This cost should be reported on the applicable payroll lines on the cost report for the employees salary groupings.

C. Health, disability, dental, etc., insurances for employees/owners shall be an allowable costs.

(K) Education and Training Expenses.

1. The cost of on-the-job training which directly benefits the quality of health care or administration at the facility shall be allowable, except for costs associated with Nurse Aide Training and Competency Evaluation Program.

2. Costs of education and training shall include travel costs but will not include leaves of absence or sabbaticals.

(L) Organizational Costs

1. Organizational cost items include the following: legal fees incurred in establishing the corporation or other organizations; necessary accounting fees; expenses of temporary directors and organizational meetings of directors and stock-holders; and fees paid to states for incorporation.

2. Organizational costs shall be amortized ratably over a period of sixty (60) months beginning with the date of organization. When the provider enters the program more than sixty (60) months after the date of organization, no organizational costs shall be recognized.

3. Where a provider is organized within a five (5) year period prior to its entry into the program and has properly capitalized organizational costs using a sixty (60) month amortization period, no change in the rate of amortization is required. In this instance the unamortized portion of organizational costs is an allowable cost under the program and shall be amortized over the remaining part of the sixty (60) month period.

4. For change in ownership after July 18, 1984, allowable amortization will be limited to the prior owner's allowable unamortized portion of organizational cost.

(M) Advertising Costs. Advertising costs which are reasonable and appropriate are allowable. The costs must be a common and accepted occurrence for providing nursing facility services.

(N) Cost of Supplies and Services Involving Related Parties. Costs of goods and services furnished by related parties shall not exceed the lower of the cost to the supplier or the prices of comparable goods or services obtained elsewhere. In the cost report a provider shall identify related party suppliers and the type, the quantity and costs to the related party for goods and services obtained from each such supplier.

(O) Minimum Utilization. In the event the occupancy rate of a facility is below eighty-five percent (85%), the administration and capital cost components will be adjusted as though the provider experienced eighty-five percent (85%) occupancy. In no case may costs disallowed under this provision be carried forward to succeeding periods.

(P) Central Office/Home Office or Management Company Costs. The allowability of the individual cost items contained within central office/home office or management company costs will be determined in accordance with all other provisions of this plan. The total of central office/home office and/or management company costs, as reported on lines 129 and 130 of the cost report, version MSIR (7-93), are limited to seven percent (7%) of gross revenues less contractual allowances.

(Q) Start-Up Costs. Expenses incurred prior to opening, as defined in HIM-15 as start-up costs, shall be amortized on a straight line method over sixty (60) months. The amortization shall be reported on the same line on the cost report as the original start-up costs are reported. For example, RN salary prior to opening would be amortized over sixty (60) months and would be reported on line 49, RN.

(R) Reusable Items. Costs incurred for items, such as linen and bedding, but not limited to, shall be classified as inventory when purchased and expensed as the item is used.

(S) Nursing Facility Reimbursement Allowance (NFRA). Effective October 1, 1996, the fee assessed to nursing facilities in the State of Missouri for the privilege of doing business in the state will be an allowable cost.

(8) Non-Allowable Costs. Non-allowable costs are costs not reasonably related to nursing facility services and include, but are not limited to, the following:

(A) Amortization on intangible assets, such as goodwill, leasehold rights, covenants and purchased certificates of need;

(B) Bad debts, contractual allowances, courtesy discounts, charity allowances, and similar adjustments or allowances are offsets to revenues and, therefore, not included in allowable costs;

(C) Capital cost increases due solely to changes in ownership;

(D) Charitable contributions;

(E) Compensation paid to a relative or an owner through a related party to the extent it exceeds the limitations established under subsection (7)(A) of this plan;

(F) Costs such as legal fees, accounting and administrative costs, travel costs, and the costs of feasibility studies, which are attributable to the negotiation or settlement of the sale or purchase of any capital asset by acquisition or merger for which any payment has been previously made under the program;

(G) Directors' fees included on the cost report in excess of two-hundred dollars ($200) per month, per individual;

(H) Federal, state or local income and excess profit taxes, including any interest and penalties paid thereon;

(I) Late charges and penalties;

(J) Finder's fees;

(K) Fund-raising expenses;

(L) Interest expense on loans for intangible assets;

(M) Legal fees related to litigation involving the Department and attorneys fees which are not related to the provision of nursing facility services, such as litigation related to disputes between or among owners, operators or administrators;

(N) Life insurance premiums for officers and owners and related parties except the amount relating to a bona fide nondiscriminatory employee benefits plan;

(O) Non-covered supplies, services and items as defined in section (6);

(P) Owner's Compensation in excess of the applicable range of the most recent survey of administrative salaries paid to individuals other than owners for proprietary and non-proprietary providers as published in the updated Medicare Provider Reimbursement Manual Part 1, Section 905.2 and based upon the total number of working hours.

1. The applicable range will be determined as follows:

   A. The number of licensed beds owned or managed.

   B. Owner/administrators will be adjusted on the basis of the high range. Owners included in home office costs or management company costs will be adjusted on the high range. All others will be calculated on the median range;

2. The salary identified in 1. above will be apportioned on the basis of hours worked in the facility/ies, home office or management company as applicable to total hours in the facility/ies, home office or management company.

(Q) Prescription drugs;

(R) Religious items or supplies or services of a primarily religious nature performed by priests, rabbis, ministers or other similar types of professionals;

(S) Research costs;

(T) Resident personal purchases provided non-routinely to residents for personal comfort or convenience;

(U) Salaries, wages or fees paid to nonworking officers, employees or consultants;

(V) Cost of stockholder meetings or stock proxy expenses;

(W) Taxes or assessments for which exemptions are available;

(X) Value of services (imputed or actual) rendered by nonpaid workers or volunteers;

(Y) All costs associated with Nurse Aide Training and Competency Evaluation Program; and

(Z) Losses from disposal of assets.

(9) Revenue Offsets

(A) Revenues other than room and board shall be classified as other revenues and must be identified separately in the cost report and offset against expenses. Such revenues include, but are not limited to, the following:

1. Income from telephone services;
2. Sale of employee and guest meals;
3. Sale of medical abstracts;
4. Sale of scrap and waste food or materials;
5. Cash, trade, quantity, time and other discounts;
6. Purchase rebates and refunds;
7. Recovery on insured loss;
8. Parking lot revenues;
9. Vending machine commissions or profits;
10. Sales from supplies to individuals other than nursing facility recipients;
11. Room reservation charges other than covered therapeutic home leave days and hospital leave days;
12. Barber and beauty shop revenue;
13. Private room differential;

14. Medicare Part B revenues;

    A. Total revenues received from Part B charges through Medicare intermediaries will be offset;

    B. Seventy-five percent (75%) of the total revenues received from Part B charges through Medicare carriers will be offset;

15. Personal services;

16. Activity income; and

17. Revenue recorded for donated services and commodities.

(B) Restricted funds designated by the donor prior to the donation for payment of operating costs will be offset from the associated cost.

(C) Restricted funds designated by the donor for capital expenditures will not be offset from allowable expenses.

(D) Unrestricted funds not designated by the provider for future capital expenditures will be offset from allowable cost.

(E) As applicable, restricted and unrestricted funds will be offset in each cost component, excluding capital, in an amount equal to the cost component's proportionate share of allowable expense.

(F) Any tax levies which are collected by nursing home districts or county homes that are supported in whole or in part by these levies, will not be offset.

(G) Gains on disposal of assets will not be offset from allowable expenses.

(10) Provider Reporting and Record Keeping Requirements.

(A) Annual Cost Report.

1. Each provider shall adopt the same twelve (12) month fiscal period for completing its cost report as is used for federal income tax reporting.

2. Each provider is required to complete and submit to the Division an annual cost report, including all worksheets, attachments, schedules and requests for additional information from the Division. The cost report shall be submitted on forms provided by the Division for that purpose. Any substitute or computer generated cost report must have prior approval by the Division.

3. All cost reports shall be completed in accordance with the requirements of this plan and the cost report instructions. Financial reporting shall adhere to GAAP, except as otherwise specifically indicated in this plan.

4. The cost report submitted must be based on the accrual basis of accounting. Governmental institutions operating on a cash or modified cash basis of accounting may continue to report on that basis, provided appropriate treatment for capital expenditures is made under GAAP.

5. Cost reports shall be submitted by the first day of the sixth month following the close of the fiscal period.

6. If a cost report is more than ten (10) days past due, payment shall be withheld from the facility until the cost report is submitted. Upon receipt of a cost report prepared in accordance with this plan, the payments that were withheld will be released to the provider. For cost reports which are more than ninety (90) days past due, the Department may terminate the provider's Medicaid participation agreement and if terminated retain all payments which have been withheld pursuant to this provision.

7. Copies of signed agreements and other significant documents related to the provider's operation and provision of care to Medicaid recipients must be attached (unless otherwise noted) to the cost report at the time of filing unless current and accurate copies have already been filed with the Division. Material which must be submitted or available upon request includes the following, but may include other documents to assist the Division's understanding of the submitted cost report.

A. Audit prepared by an independent accountant, including disclosure statements and management letter or SEC Form 10-K;

B. Contracts or agreements involving the purchase of facilities or equipment during the last seven (7) years if requested by the Division, the Department or its agents;

C. Contracts or agreements with owners or related parties;

D. Contracts with consultants;

E. Documentation of expenditures, by line item, made under all restricted and unrestricted grants;

F. Federal and state income tax returns for the fiscal year, if requested by the Division, the Department or its agents;

G. Leases and/or rental agreements related to the activities of the provider if requested by the Division, the Department or its agents;

H. Management contracts;

I. Medicare cost report, if applicable;

J. Review and compilation statement;

K. Statement verifying the restrictions as specified by the donor, prior to donation, for all restricted grants;

L. Working trial balance actually used to prepare the cost report with line number tracing notations or similar identifications; and

M. Schedule of capital assets with corresponding debt.

8. Cost reports must be fully, clearly and accurately completed. All required attachments must be submitted before a cost report is considered complete. If any additional information, documentation or clarification requested by the Division or its authorized agent is not provided within fourteen (14) days of the date of receipt of the Division's request, payments may be withheld from the facility until the information is submitted.

9. Under no circumstances will the Division accept amended cost reports for rate determination or rate adjustment after the date of the Division's notification of the final determination of the rate.

(B) Certification of Cost Reports.

1. The accuracy and validity of the cost report must be certified by the provider. Certification must be made by a person authorized by one (1) of the following: for an incorporated entity, an officer of the corporation; for a partnership, a partner; for a sole proprietorship or sole owner, the owner or licensed operator; or for a public facility, the chief administrative officer of the facility. Proof of such authorization shall be furnished upon request.

2. Cost reports must be notarized by a commissioned notary public.

3. The following statement must be signed on each cost report to certify its accuracy and validity:

Certification Statement: Misrepresentation or falsification of any information contained in this cost report may be punishable by fine and/or imprisonment under state or federal law.

I hereby certify that I have read the above statement and that I have examined the accompanying cost report and supporting schedules prepared by (provider name and number) for the cost report period beginning (date/year) and ending (date/year), and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted.

____________________ ____________ ______
Signature Title Date

(C) Adequate Records and Documentation.

1. A provider must keep records in accordance with GAAP and maintain sufficient internal control and documentation to satisfy audit requirements and other requirements of this plan, including reasonable requests by the Division or its authorized agent for additional information.

2. Each of a provider's funded accounts must be separately maintained with all account activity clearly identified.

3. Adequate documentation for all line items on the cost report shall be maintained by a provider. Upon request, all original documentation and records must be made available for review by the Division or its authorized agent at the same site at which the services were provided or at the central office/home office if located in the State of Missouri. Copies of documentation and records shall be submitted to the Division or its authorized agent upon request.

4. Each facility shall retain all financial information, data and records relating to the operation and reimbursement of the facility for a period of not less than seven(7) years.

(D) Audits.

1. Any cost report submitted may be subject to field audit by the Division or its authorized agent.

2. A provider shall have available at the field audit location one (1) or more knowledgeable persons authorized by the provider and capable of explaining the provider's accounting and control system and cost report preparation, including all attachments and allocations.

3. If a provider maintains any records or documentation at a location which is not the same as the site where services were provided, other than central offices/home offices not located in the State of Missouri, the provider shall transfer the records to the same facility at which the Medicaid services were provided, or the provider must reimburse the Division or its authorized agent for reasonable travel costs necessary to perform any part of the field audit in any off-site location, if the location is acceptable to the Division.

4. Those providers initially entering the program shall be required to have an annual independent audit of the financial records, used to prepare annual cost reports covering at a minimum the first two (2) full twelve (12) month fiscal years of their participation in the Medicaid Program, in accordance with GAAP and Generally Accepted Auditing Standards. The audit shall include, but may not be limited to, the Balance Sheet, Income Statement, Statement of Retained Earnings and Statement of Cash Flow. For example, a provider begins participation in the Medicaid Program in March and chooses a fiscal year of October 1 to September 30. The first cost report will cover March through September. That cost report may be audited at the option of the provider. The October 1 to September 30 cost report, the first full twelve (12) month fiscal year cost report, shall be audited. The next October 1 to September 30 cost report, the second full twelve (12) month cost report, shall be audited. The audits shall be done by an independent certified public accountant.

(E) Change in Provider Status.

1. If a provider notifies, in writing, the Director of the Institutional Reimbursement Unit of the Division prior to the change of control, ownership or termination of participation in the Medicaid Program, the Division will withhold all remaining payments from the selling provider until the cost report is filed. The fully completed cost report with all required attachments and documentation is due the first day of the sixth month after the date of change of control, ownership or termination. Upon receipt of a cost report prepared in accordance with this plan, any payment that was withheld will be released to the selling provider.

2. If the Director of the Institutional Reimbursement Unit does not receive, in writing, notification of a change of control or ownership and a cost report ending with the date of the change of control or ownership, upon learning of a change of control or ownership, $30,000 of the next available full month Medicaid payment, after learning of the change of control or ownership, will be withheld from the provider identified in the current Medicaid participation agreement until a cost report is filed. If the Medicaid payment is less than $30,000, the entire payment will be withheld. Once the cost report, prepared in accordance with this plan, is received the payment will be released to the provider identified in the current Medicaid participation agreement.

3. The Division of Medical Services may, at its discretion, delay the withholding of funds specified in paragraphs (10)(E)1. and 2. until the cost report is due based on assurances satisfactory to the division that the cost report will be timely filed. A request jointly submitted by the buying and selling provider may provide adequate assurances. The buying provider must accept responsibility for ensuring timely filing of the cost report and authorize the division to immediately withhold thirty thousand dollars ($30,000) if the cost report is not timely filed.

(F) Joint Use of Resources.

1. If a provider has business enterprises in addition to the nursing facility, the revenues, expenses, statistical and financial records of each separate enterprise shall be clearly identifiable.

2. When the facility is owned, controlled or managed by an entity or entities that own, control or manage one (1) or more other facilities, records of central office and other costs incurred outside the facility shall be maintained so as to separately identify revenues and expenses of, and allocations to, individual facilities. Direct allocation of cost, such as RN consultant, which can be directly identifiable in the central office/home office cost and directly allocated to a facility by actual amounts or actual time spent. These direct costs shall be reported on the appropriate lines of the cost report. Allocation of central office/home office or management company costs to individual facilities should be consistent from year to year. If a desk audit or field audit establishes that records are not maintained so as to clearly identify information required by this plan, those commingled costs shall not be recognized as allowable costs in determining the facility's Medicaid reimbursement rate. Allowability of these costs shall be determined in accordance with the provisions of this plan.

(11) Cost Components and Per Diem Calculation. The Division will use a cost report which has an ending date in calendar year 1992 which is on file with the Division as of December 31, 1993. No amended cost report will be accepted after December 31, 1993. If a facility has more than one cost report with periods ending in calendar year 1992, the cost report covering a full twelve (12) month period ending in calendar year 1992 will be used. If none of the cost reports cover a full twelve (12) months, the cost report with the latest period ending in calendar year 1992 will be used.

(A) Patient Care. Each nursing facility's patient care per diem shall be the lower of:

1. Allowable cost per patient day for patient care as determined by the Division from the 1992 cost report trended by the HCFA Market Basket Index for 1993 of 3.9%, 1994 of 3.4% and nine months of 1995 of 3.3%, for a total of 10.6%; or

2. The per diem ceiling of 120% of the patient care median determined by the Division from the databank.

(B) Ancillary. Each nursing facility's ancillary per diem will be the lower of:

1. Allowable cost per patient day for ancillary as determined by the Division from the 1992 cost report, trended by the HCFA Market Basket Index for 1993 of 3.9%, 1994 of 3.4% and nine months of 1995 of 3.3%, for a total of 10.6%; or

2. The per diem ceiling of 120% of the ancillary median determined by the Division from the databank.

(C) Administration. Each nursing facility's administration per diem shall be the lower of:

1. Allowable cost per patient day for administration as determined by the Division from the 1992 cost report, trended by the HCFA Market Basket Index for 1993 of 3.9%, 1994 of 3.4% and nine months of 1995 of 3.3%, for a total of 10.6% and adjusted for minimum utilization, if applicable, as described in subsection (7)(O); or

2. The per diem ceiling of 110% of the administration median determined by the Division from the databank.

(D) Capital. Each nursing facility's capital per diem shall be determined using the Fair Rental Value System as follows:

1. Rental Value.

A. Determine the total asset value.

(I) Determine facility size from the 1992 desk audited and/or field audited cost report;

(II) Determine the number of increased licensed beds after the end of the facility's 1992 desk audited and/or field audited cost report but prior to July 1, 1994;

(III) Determine the bed equivalency for renovations/major improvements prior to July 1, 1994, by taking the cost of the renovations/major improvements divided by the asset value per bed for the year of the renovation/major improvement rounded to the nearest whole bed. The cost must be at least the asset value per bed for the year of the renovation/major improvement. For example, a renovations/major improvements cost of $200,000 is equal to 6 beds. ($200,000/ $32,330 equals 6.19 beds rounded to 6 beds); and

(IV) Determine the number of decreased licensed beds after the end of the facility's 1992 cost report but prior to July 1, 1994.

(V) Sum of (I), (II), (III) less (IV) times the asset value is the Total Asset Value.

B. Determine the reduction for age by multiplying the age of the beds by one percent (1%) up to forty percent (40%). For multiple licensing dates, the result of the weighted average age calculation will be limited to forty percent (40%).

(I) The age of the beds for multiple licensing dates is calculated on a weighted average method rounded to the nearest whole year. For example, a facility with original licensure in 1977 of 60 beds and an additional licensure of 60 beds in 1982 and 10 beds in 1993, the reduction is calculated as follows:

Licensure Year	Age	Beds	Age x Beds
1977	17	60	1020
1982	12	60	720
1993	1	10	10
Total		130	1,750

Weighted Average Age - 1750/130 beds = 13.5 years rounded to 14 years. This results in a reduction for age of the beds of 14%.

(II) The age of the beds for replacement beds is calculated on a weighted average method rounded to the nearest whole year with the oldest beds always being replaced first. For example, a facility with 120 beds licensed in 1978 with replacement of 60 beds in 1988, the reduction is calculated as follows:

License Yr	Age	Beds	Age x Beds
1978	16	60	960
1988	6	60	360
Total		120	1,320

Weighted Average Age - 1320/120 = 11 years. This results in a reduction for age of the beds of 11%.

(III) The age of the beds for reductions in licensed beds is calculated on a weighted average method rounded to the nearest whole year with the oldest beds always being delicensed first. For example, a facility with original licensure in 1977 of 60 beds, additional licensure of 60 beds in 1982 and 10 beds in 1993 and a reduction of 10 beds in 1985, the reduction percentage is calculated as follows:

Licensure Year	Age	Beds	Age x Beds
1977	17	60	1,020
1982	12	60	720
1993	1	10	10
1985*	17	(10)	(170)
Total		120	1,580

* reduction of 1977 beds

Weighted Average Age - 1580/120 beds = 13.2 years rounded to 13 years. This results in a reduction for age of the beds of 13%.

(IV) The age of the beds equivalents for renovations/major improvements is calculated on a weighted average method rounded to the nearest whole year. For example, a 120 bed facility licensed in 1978 undertakes two renovations: $200,000 in 1983 and $100,000 in 1993. The asset value per bed is $32,330. The bed equivalency is 6 beds for 1983 and 3 beds for 1993, the reduction percentage is calculated as follows:

Licensure/ Construction Year	Age	Beds	Age x Beds
1978	16	120	1,920
1983	11	6	66
1993	1	3	3
Total		129	1,989

Weighted Average Method - 1989/129 = 15.42 years rounded to 15 years. This results in a reduction for age of beds of 15%.